INTRADEPARTMENTAL CORRESPONDENCE

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TO: The Honorable Board of Police Commissioners

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OFFICE OF THE INSPECTOR GENERAL

FROM: Chief of Police

SUBJECT: IN-CUSTODY DEATH FID NO. 031-19

Honorable Members:

The following is my review, analysis, and findings for In-Custody Death (ICD), Force Investigation Division (FID) No. 031-19. A Use of Force Review Board (UOFRB) was convened on this matter on April 1, 2020. I have reviewed and adopted the recommendations from the UOFRB for this incident. I hereby submit my findings in accordance with Police Commission policy.

SUMMARY[1]

On Friday, July 12, 2019, at 1600 hours, Officers A. Pacheco, Serial No. 38464, and M. Mann, Serial No. 40912, Central Area Narcotics Enforcement Detail (NED), were monitoring the area of San Pedro Street and 4th Street for narcotics activity while assigned to a coordinated intra-departmental task force for narcotics enforcement in Central Area. The officers observed a male, later identified as L. Baca involved in an apparent narcotics transaction with another male, later identified as J. Flores. Baca handed Flores an unknown amount of U.S. currency for which Flores handed a small dark substance to Baca. Baca then wrapped the substance in white plastic. Officer Pacheco formed the belief that Baca had purchased heroin from Flores.

According to the FID investigation, this information was broadcast to Officers C. Heistermann, Serial No. 40775, and E. Haskell, Serial No. 41440, Central Patrol Division, who were in full uniform assigned as the chase/takedown team for the task force. Officers Heistermann and Haskell detained Baca without incident. Baca was searched and a brown, tar-like substance resembling heroin was recovered. Baca was subsequently placed under arrest for California Health and Safety Code section 11350(a), Possession of Narcotics. Officers Heistermann and Haskell transported Baca to the Central Community Police Station (CPS).

Note: The FID investigation confirmed that no force was used in the detention or arrest of Baca.

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[1] The summary and the investigation completed by FID for this incident have been provided to the Board of Police Commissioners.

According to the FID investigation, Sergeant J. Sterling, Serial No. 35950, Central Patrol Division, was the watch commander and completed the Adult Detention Log and pre-booking inspection of Baca. Baca denied having any injuries or illnesses. At 1900 hours, Officer Mann partially completed an Arrestee Medical Screening Form. When questioned by Officer Mann, Baca advised he did not have any injuries, nor did he require medical attention **(Additional – Incomplete Arrestee Medical Screening Form).**

> **Note:** The FID investigation revealed that the Arrestee Medical Screening Form indicated that Baca had open wounds on his right leg. When interviewed by FID investigators, Officer Mann stated that he did not observe any injuries on Baca. The FID investigation was unable to determine the source of the notation of the open wound on the Arrestee Medical Screening Form.[2]

According to the FID investigation, at approximately 1956 hours, Detectives T. Penson, Serial No. 30488, and J. Trejo, Serial No. 34438, Central Area NED, transported Baca from Central CPS to Metropolitan Jail Section (MJS) for booking. Baca did not exhibit any indication of medical distress or suffer from any injuries. On July 13, 2019, at 0318 hours, while being processed at MJS, Baca met with Registered Nurse M. Deguia, Medical Services Division (MSD) and Physician Assistant L. Hitchcock, MSD, with regard to pre-existing wounds on his right leg. According to Physician Assistant Hitchcock, there was, "No need for wound care because it was scabbed over so there was no need to really address that."[3] Additionally, Baca advised the medical staff that he was a heroin user and was experiencing withdrawal symptoms. Upon examination, it was determined that Baca's blood pressure was slightly elevated and that he was experiencing muscle cramps.

According to Physician Assistant Hitchcock, Baca *appeared to be uncomfortable* due to the physical symptoms associated with heroin withdrawal. Physician Assistant Hitchcock ordered *several medications* to be administered on an *as needed* basis to Baca. Physician Assistant Hitchcock also prescribed to Baca the following medications: *Tylenol 975, three times a day as needed; Loperamide, two milligrams, three times a day as needed; Compazine which is for nausea, 10 milligrams, three times a day as needed; Robaxin or Methocarbamol 750, three times a day, as needed for muscle spasms; and Bentyl, 20 milligrams, three times a day for abdomen pain.* At the conclusion of Baca's medical exam, Physician Assistant Hitchcock placed Baca on the Q4 Protocol.[4]

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[2] FID attempted to identify through interviews the source of the notation on the Arrestee Medical Screening Form. At the conclusion of all interviews, FID was unable to make a positive identification as to who made the notation.
[3] The absence of open wounds was supported by Doctor Robyn Parks, Associate Deputy Medical Examiner. The Autopsy Report for Baca noted, "There are multiple healed, old scars scattered between the right knee and right lower anterior and posterior leg."
[4] The Q4 Protocol is an opiate withdrawal protocol that requires nurses to check on inmates every four hours and to provide them with prescribed medication, as needed. Nurses check for overall alertness and symptoms such as diarrhea, vomiting, and dehydration. The Q4 Protocol also allows for the absence of two consecutive Q4 checks at the inmate's discretion. The inmate must present him/herself on the third Q4 check. Failure to present on the third Q4 check will require a Detention Officer to enter the inmate's cell and contact the inmate. The allowance of two missed Q4 checks is to permit the inmate undisturbed sleep.

According to the FID investigation, at approximately 0508 hours, Baca was placed in the general population, South-D housing module, where he was housed with seven to twenty-three other inmates over the course of the next 26 hours. During that time period, the South-D module was the subject of a total of 53, Title 15, Section 1027, safety checks.[5]

According to Registered Nurse E. Smith, MSD, he conducted the July 13, 2019, general population, South-D housing module, Q4 checks at 0900 hours, 1300 hours, and 1730 hours; wherein, Baca did not present himself for medical assessment during the 1730 hours Q4 check. In accordance with protocol for the third missed Q4 check, Nurse Smith asked Officer G. Lee, Serial No. 42942, Custody Services Division (CSD), to enter the module and bring Baca to the module door for medical assessment. Nurse Smith stated that Officer Lee entered the module and located Baca in a bunk. Officer Lee advised Baca that Nurse Smith wanted to see him, to which Baca replied, "I don't want to." Upon Baca's refusal for medical assessment, Nurse Smith proceeded with the other required Q4 checks.

According to Officer Lee, he entered the general population, South-D housing module to locate Baca at the request of Nurse Smith. Officer Lee located Baca lying in bed. Officer Lee asked Baca *if he's okay.* Officer Lee observed that Baca *looked fine* and noted that Baca did not *complain of anything.* Officer Lee *asked* Baca *if he needed to see a doctor* to which Baca replied that he did not need to see a doctor. Officer Lee asked Baca *if he needed anything* to which Baca *refused all the services.* Officer Lee conveyed this information to Nurse Smith, who advised Officer Lee that Baca could remain in the module. Officer Lee and Nurse Smith proceeded with the other required Q4 checks.

According to the FID investigation, on July 14, 2019, at approximately 0740 hours, Officer Lee, along with Detention Officers G. Sanchez, Serial No. N5776, and E. Ramirez, Serial No. N5054, CSD, conducted a start of watch inspection of the South-D housing module to account for each inmate.

According to Detention Officer Sanchez, during the start of watch inspection of the general population, South-D housing module, he found Baca lying on the floor with *blood on his teeth, along with labored breathing.* Detention Officer Sanchez observed that Baca *looked sick* and *asked him if he was okay.* Baca confirmed that he *was having trouble breathing.* Due to Baca's physical state, Detention Officer Sanchez obtained a wheelchair and assisted Baca to the dispensary to be seen by medical staff for his condition.

According to the FID investigation, at approximately 0750 hours, Registered Nurse J. McVicker, MSD, examined Baca at the dispensary. According to Nurse McVicker, Baca *was complaining of some symptoms* related to *his heroin withdrawal,* specifically *abdominal pain and nausea,* which the medical staff *previously already knew about as* Baca *had seen medical when he first came in.* Baca *was already on the Q4 list.* MSD staff *knew that this was an issue* and *were*

[5] The California Code of Regulations, Title 15, Section 1027, requires hourly safety checks of inmates. A safety check is a direct, visual observation performed at random intervals to provide for the health and welfare of inmates. Safety checks shall be done in person. Audio/video monitoring may supplement, but not substitute, for direct visual observation.

checking on him every four hours. MJS staff *brought him down this morning* and Baca was dispensed *the protocol medications* for heroin withdrawal. Nurse McVicker administered Bentyl to treat stomach cramps, Compazine to treat nausea, and Methocarbamol, a muscle relaxer. After administering the medication, Nurse McVicker cleared Baca to return to the general population South-D housing module.

According to Detention Officer Sanchez, while *in the dispensary,* Baca advised *dispensary staff that he was coming off of heroin and that he was in a lot of pain.* The dispensary staff *took his blood pressure, gave him some medication,* and advised him that Baca *was okay to take back up.*

According to Nurse McVicker, she subsequently advised Registered Nurse J. Gonzales, MSD, that Baca *got his medication already* and stated to her, "Hey, when you go upstairs, this guy's already been medicated."

According to the FID investigation, at approximately 0800 hours, prior to Baca being returned to the general population, South-D housing module, Detention Officer Ramirez directed Officer Lee and Detention Officer Sanchez to place Baca into South-B-102, a single occupant cell which was comprised of a bed, sink, toilet, and security camera. Baca remained in this cell for nine hours and two minutes, and was the subject of a total of 17, Title 15, Section 1027, safety checks (**Additional – Administrative Segregation** and **CSD Observation Logs – Inmate Tracking**).

According to Detention Officer Ramirez, he believed Baca was in a weakened state. He was concerned that if Baca was returned to the general population South-D housing module, he could be *messed with* by other arrestees. Detention Officer Ramirez also considered that *if Baca was not feeling well, Baca may not be able to come to the cell door during meal times to show his wristband, as required which would then obligate jail personnel to enter into the general population cell to find Baca.* Detention Officer Ramirez also believed that Baca would be more comfortable in a segregated cell and that medical, along with jail personnel, would be better able to communicate with him more efficiently than if he was in a general population cell (**Additional – Administrative Segregation**).

The FID investigation revealed that on July 14, 2019, at 0900 hours, Registered Nurse J. Gonzales, MSD, was unaccompanied during a Q4 check of the South-B housing module (**Additional – Unescorted Medical Staff**).

According to Detention Officer J. Erby, Serial No. N4605, CSD, he had conducted *noon checks on all of the pods.* He recalled that when he did his check on Baca, he observed Baca *laying down on the bed with his blanket* and that he *was breathing.*

According to the FID investigation, at approximately 1310 hours, Nurse Gonzales performed the Q4 check for the South-B housing module which included cell, South-B-102. Nurse Gonzales stated that her *assignment was to do the* Q4 *check at one o'clock.* Although *there was no medication due for* Baca at that time, MSD personnel still checked on the welfare of persons in custody at MJS. When Nurse Gonzales stopped in front of Baca's cell door (South-B-102) to check on Baca, she observed that Baca was lying on his bunk. Nurse Gonzales observed that his

tray of food was still on the little window. Nurse Gonzales attempted to get Baca to eat his lunch by saying, "Come up, get up and get your food." Baca walked to the door and picked up his lunch from the cell port. Nurse Gonzales asked Baca if he was okay and he replied, "Yeah." Nurse Gonzales stated that she observed that Baca appeared to be tired, which was a side effect consistent with the medications he had received earlier in the day for heroin withdrawal.

According to the FID investigation, at approximately 1611 hours, prior to entering the South-B housing module, Detention Officer Kenneth Mason, Serial No. N5989, CSD, documented the Title 15 safety check by pre-signing the CSD observation log. Detention Officer Mason then entered the South-B housing module and performed the required Title 15 safety checks. Detention Officer Mason stopped and looked through Baca's cell door window, wherein, he observed Baca sitting on the toilet. Detention Officer Mason stated, "He was alive. His stomach was moving, his chest was rising." Detention Officer Mason was not *alarmed* and did not *go into the cell, bang on the window or anything like that because a lot of people fall asleep when they're on the stool* (toilet). Detention Officer Mason *went by and continued doing* his *checks* (**Additional – Documentation of Title 15 Safety Checks**).

> **Note:** A review of the MJS surveillance video by FID investigators revealed that Baca seated himself on the toilet in cell, South-B-102 at 1608 hours, three minutes prior to Detention Officer Mason performing his safety check on Baca.

According to the FID investigation, at approximately 1632 hours, Detention Officer Mason entered the South-B housing module to perform a required Title 15, safety check. Prior to entering the module, Detention Officer Mason again pre-signed the CSD Observation Record prior to completing the safety check. However, before Detention Officer Mason initiated the Title 15 safety checks, he was contacted via intercom by Detention Officer Ramirez. Detention Officer Mason was directed by Detention Officer Ramirez to the second level of the South-B module to escort inmate M. Williams out of the module for transportation to another facility. Detention Officer Mason escorted Williams past Baca's cell at 1637 hours. Detention Officer Mason stated he could see Baca in his peripheral vision still seated on the toilet, but he did not stop and look directly into the cell. According to Detention Officer Mason, *since* he *had an inmate* (Williams) *in front of* him, Detention Officer Mason "couldn't take his eyes off that inmate," because he was alone with the inmate. As a result of the escort, Detention Officer Mason left the South-B housing module without completing the safety checks and did not return to complete them. Detention Officer Mason also failed to notify a supervisor that the Title 15 safety checks had not been conducted, or that no other additional CSD personnel had completed the Title 15 safety checks for this time period (**Additional – Documentation of Title 15 Safety Checks / Missed Title 15 Safety Check** and **Improper Inmate Escort**).[6]

> **Note:** The FID investigation revealed that Detention Officer Mason did not handcuff inmate Williams, who had been arrested for robbery, prior to conducting the escort and Detention Officer Mason escorted Williams alone **(Additional - Improper Inmate Escort).**

[6] FID investigators reviewed CSD Observation Records documenting the Title 15 safety checks conducted in the South-B housing module on July 14, 2019. These records were compared to the MJS security video and it was determined that all prior checks were completed in accordance with Department policy.

According to the FID investigation, Officer Lee stated that at approximately 1701 hours, he was conducting the required Title 15 safety check in the South-B housing module, when he looked into cell South-B-102. Officer Lee observed Baca sitting on the toilet with the right side of Baca's body leaning against the west wall. Officer Lee knocked on the window with his hand and obtained no response from Baca. Officer Lee observed that Baca was drooling and believed Baca was unconscious or deceased. Officer Lee utilized his hand-held radio to request Detention Officer Ramirez to open Baca's cell door. Once the door was open, Officer Lee stepped inside, alone, and attempted to awaken Baca, who did not respond. Officer Lee utilized his hand-held radio to broadcast that Baca was not breathing and then repeated the information that Baca was not breathing over the cell's intercom as well. Officer Lee was unable to locate a pulse on Baca. Due to Baca's critical state, Officer Lee repositioned Baca from his seated position on the toilet, to a supine position on the floor to start Cardiopulmonary Resuscitation (CPR) (**Additional - Improper Radio Broadcast**).

> **Note:** A review of MJS surveillance video by FID investigators determined that Baca's last observed movement was at 1613 hours, which was 48 minutes before he was observed by Officer Lee at 1701 hours.

According to the FID investigation, at approximately 1703 hours, Detention Officers Ramirez and Sanchez, along with Nurse Gonzales and Officer K. Campbell, Serial No. 43004, CSD, arrived in South-B housing module to assist Officer Lee. Nurse Gonzales assisted Officer Lee with moving Baca outside of the cell, where they worked together to perform CPR. Officer Lee performed chest compressions, while Nurse Gonzales held Baca's head and maintained an open airway.

According to Detention Officer Ramirez, he simultaneously used his police radio to broadcast, "We have a man down in South Boy 102. The arrestee is unresponsive. We're starting CPR. I need additional personnel and medical staff." After he broadcast the *man down*, Detention Officer Ramirez obtained an Automated External Defibrillator (AED) and placed the defibrillator pads on Baca's chest and torso.[7] Although the defibrillator pads were applied to Baca and the AED was powered on, a shock was not administered because the AED did not detect a shockable heart rhythm.[8]

According to Detention Officer Erby, he heard a *man-down call in South Pod.* When he responded to B-block, he observed Baca *laying on the ground.* Detention Officer Erby observed that the officers had *already pulled* Baca *out* and had begun *to administer CPR.* Detention Officer Erby began to *monitor the scene* as he recognized that as *the first supervisor* at scene, his *job was to control* the incident. Detention Officer Erby observed that *a nurse was already there,*

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[7] The AED is an external defibrillator capable of cardiac rhythm analysis, and delivery of an electric shock to a cardiac arrest victim.

[8] The AED was recovered by FID investigators and the information stored on it was downloaded by Los Angeles Fire Department personnel. A review of that information determined that the AED device was in working order. A shock was never delivered because the AED determined Baca was pulseless.

as well as was other officers who were *already doing the CPR.* Detention Officer Erby felt that he did not *need to instruct the CPR because that was already taking place,* so he began to control the scene. He *started canvassing for witnesses in the cells* and began *to direct some of the staff that was not assisting* with *the chest compressions to remove some of the inmates that had a direct visual view of what was taking place.* Detention Officer Erby *was there the whole entire time, controlling the scene.* He also ensured personnel *taped off the scene from Door 103 to the entrance door, to block that part* and preserve the scene.

According to Detention Officer Erby, he then observed Detention Officer Ramirez retrieve the AED so it could *be on standby.* Detention Officer Erby requested *an ETA over the radio for the RA* (Rescue Ambulance) *and the fire department.* He *requested that at least two times because they had not arrived yet.* Detention Officer Erby *was concerned about* the amount of time that had lapsed. Detention Officer Erby then observed the personnel providing medical assistance place the AED pads on Baca's chest and heard the automated system state, "Stand Clear," but he was unsure if the *electricity actually went through or not.*

According to the FID investigation, at approximately 1705 hours, the on-duty MJS physician, Doctor R. Lee, MSD, arrived along with Nurses Smith and McVicker. Doctor Lee oversaw the lifesaving efforts, while Nurse Smith began ventilating Baca with a bag valve mask and Nurse McVicker prepared to administer an intravenous line (IV). Baca was provided CPR until the arrival of personnel from the Los Angeles Fire Department (LAFD). Officer Lee, Detention Officers Sanchez and Y. Bonilla, Serial No. N4955, CSD, along with Nurse Gonzales, performed chest compressions. Staff from MJS contacted the LAFD, Metropolitan Fire Communications, who dispatched LAFD Engine 4 and RA 209 to MJS.

According to Nurse McVicker, she was in the dispensary along with Nurse Smith doing an intake assessment while Nurse Gonzales *was already upstairs to do her rounds. One of the detention officers came into the dispensary* and advised Nurses McVicker and Smith, "Hey, there's a guy upstairs that's not responsive and they've already started CPR." Nurse McVicker, then *notified Dr. Lee who* "grabbed the AED, the red bag that we have with things like IV supplies and things of that nature." Nurse McVicker *went upstairs immediately.* Upon her arrival, Nurse McVicker observed that Baca was *outside of his cell on his back* and that MJS personnel *had already started CPR.* She observed that *the AED pads were on* Baca's chest, *so CPR had been initiated.* After Nurse McVicker *assessed the situation,* she *went and immediately got the Ambu Bag*[9] *to give* Baca *rescue breaths* in *between cycles of compressions* and *cycles of the AED.* Nurse McVicker searched *for any sort of heart rhythm.* Nurse McVicker allowed Nurse Smith to take over giving Baca *rescue breaths* so Nurse Gonzales and Nurse McVicker *could try to look for any kind of IV access.* Nurses Gonzales and McVicker *searched* Baca's *arms and his hands and attempted a few times,* but *were not successful at getting an IV in.*

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[9] An Ambu Bag is composed of a squeezable bag, a one-way valve, and a face mask utilized to provide a patient artificial respiration.

According to Doctor Lee, when he *heard about the man down,* he and *the two nurses, McVicker and Smith, dropped what* they *were doing immediately.* They *grabbed the Crash Bag,*[10] *the AED, and rushed upstairs. While* they *were on the way up,* they were advised *that the detention officers* had *already called 911 and that* there was *already a nurse and some detention officers on the scene.* When Doctor Lee arrived on scene, he observed that Baca *was lying down. He was pulseless, unresponsive, and CPR was already under way by the third nurse, Gonzales, and two other detention officers.* Doctor Lee observed that *the AED pads were already applied to* Baca's chest. *They were undergoing CPR and* Doctor Lee *oversaw the operation of the CPR* and *made sure that they were doing it right.* Doctor Lee also observed *quite a bit of blood coming out of* Baca's *mouth at the time.* Doctor Lee *suggested that one of the nurses grab the suctioning machine from* the dispensary and *bring it back upstairs so they can suction whatever material was coming out* of Baca's *mouth.* Doctor Lee stated the personnel at scene continued lifesaving measures *for maybe about five to ten more minutes until the paramedics arrived, after which they took over resuscitation efforts.* LAFD personnel *assumed the* lifesaving *efforts and that went on for about 20 more minutes* until LAFD personnel determined that Baca was deceased.

According to Sergeant L. Barnes, Serial No. 31709, Watch Commander, CSD, he heard the broadcast of a man down inside South Boy 102. He began to monitor the incident via his radio and also via the live-feed video cameras located within the module. Sergeant Barnes observed MJS personnel providing medical attention to Baca and heard several requests for a RA. Sergeant Barnes started a chronological log to document the incident capturing involved personnel and approximate times for the incident, which he believed would be required for the investigation. Hearing that Baca was unresponsive, Sergeant Barnes made a telephonic notification to Lieutenant J. Hernandez, Serial No. 32765, Officer In-Charge (OIC), CSD, advising him of the incident. Sergeant Barnes also notified Communications Division (CD) that he was temporarily closing MJS to in-coming arrestees.

According to the FID investigation, at approximately 1708 hours, LAFD Engine 4 arrived at the gate of the MJS facility. At approximately 1714 hours, LAFD Engine 4 personnel began medical treatment of Baca. Approximately 60 seconds later, LAFD RA 209 arrived and assisted with Baca's medical treatment. At 1729 hours Baca failed to respond to medical treatment and LAFD personnel determined Baca deceased.at scene. Once it was determined that the incident was an ICD, Sergeant Barnes directed Sergeant D. Lopez, Serial No. 39711, Assistant Watch Commander, CSD, to separate and monitor the involved personnel until the arrival of FID investigators.

On July 16, 2019, Doctor Ajay Paschal, Senior Deputy Medical Examiner, and Doctor Robyn Parks, Associate Deputy Medical Examiner, Los Angeles County Coroner's Office, performed a post-mortem examination of Baca's remains. Doctor Paschal classified the manner of death as accidental and the cause of death as resulting from an upper gastrointestinal hemorrhage, a

[10] A Crash Bag contains medical supplies required to provide emergency medical treatment. The bag contains an Ambu Bag and general medical supplies including supplies to provide intravenous therapy which is used to provide fluid replacement or deliver medications.

perforated gastric ulcer, gastric varices, and portal hypertension arising from cirrhosis.[11] Methamphetamine toxicity and hypertensive cardiovascular disease were also determined to be contributing factors in Baca's death.[12]

On September 06, 2019, a Laboratory Analysis Summary Report approved by Supervising Criminalist Sarah Buxton de Quintana, Los Angeles County Department of Coroner, presented an analysis of Baca's blood results. Baca had .08 ug/mL of methamphetamine in a blood sample that was taken from inside of his femoral artery. Baca also had .16 ug/mL of methamphetamine and .03 ug/mL of amphetamine in a blood sample that was taken from his heart.

> **Note:** The Los Angeles County Department of Coroner Medical Staff indicated that any level of methamphetamine within Baca's blood could be considered a lethal amount due to its chemical make-up. Additionally, the Los Angeles County Department of Coroner Medical Staff was unable to determine the time of ingestion of the methamphetamine by Baca.

FINDINGS

There was no Use of Force related to Baca's detention or arrest. The UOFRB determined, and I concur, that the actions of the involved Central Patrol Division and Custody Services Division personnel did not contribute to Baca's death; therefore, individual findings are not required.

Tactics – Does Not Apply (No "substantially involved" personnel).

Drawing/Exhibiting – Does Not Apply.

Lethal Use of Force – Does Not Apply.

ANALYSIS[13]

Detention

Officers Pacheco and Mann observed Baca involved in a purchase of illegal narcotics and directed Officers Heistermann and Haskell to conduct an investigative stop on Baca. Officers Heistermann and Haskell detained Baca without incident. A brown, a tar-like substance resembling heroin, wrapped in white plastic, was recovered from Baca who was subsequently placed under arrest for the Possession of Narcotics. The officers' actions were appropriate and within Department policies and procedures.

Captain T. Harrelson, Serial No. 32090, Commanding Officer, Central Area, conducted an analysis of the actions of the responding and involved officers. His analysis included a review of

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[11] Gastric varices are abnormal, enlarged veins in the stomach.
[12] Autopsy Report No. 2019-05293, Los Angeles County Department of Medical Examiner-Coroner.
[13] The analysis reflects my recommendations as supported by the preponderance of the evidence established by the investigation.

tactics, adherence to procedures, and coordination of resources. Captain Harrelson did not note any deviations from Department policy.

Tactical De-Escalation

Tactical de-escalation involves the use of techniques to reduce the intensity of an encounter with a suspect and enable an officer to have additional options to gain voluntary compliance or mitigate the need to use a higher level of force while maintaining control of the situation.
Tactical De-Escalation Techniques

- ***P**lanning*
- ***A**ssessment*
- ***T**ime*
- ***R**edeployment and/or Containment*
- ***O**ther Resources*
- ***L**ines of Communication (Use of Force - Tactics Directive No. 16, October 2016, Tactical De-Escalation Techniques)*

Tactical de-escalation does not require that an officer compromise his or her safety or increase the risk of physical harm to the public. De-escalation techniques should only be used when it is safe and prudent to do so.

In this case, the involved personnel were maintaining custody of the suspect at the time of this incident and were not engaged in any tactical operations. Therefore, the incident was not evaluated for Tactical De-escalation.

Command and Control

Command and Control is the use of active leadership to direct others while using available resources to coordinate a response, accomplish tasks and minimize risk. Command uses active leadership to establish order, provide stability and structure, set objectives and create conditions under which the function of control can be achieved with minimal risk. Control implements the plan of action while continuously assessing the situation, making necessary adjustments, managing resources, managing the scope of the incident (containment), and evaluating whether existing Department protocols apply to the incident.

Command and Control is a process where designated personnel use active leadership to command others while using available resources to accomplish tasks and minimize risk. Active leadership provides clear, concise, and unambiguous communication to develop and implement a plan, direct personnel and manage resources. The senior officer or any person on scene who has gained sufficient situational awareness shall initiate Command and Control and develop a plan of action. Command and Control will provide direction, help manage resources, and make it possible to achieve the desired outcome. Early considerations of PATROL will assist with the Command and Control process (Los Angeles Police Department, Training Bulletin, Volume XLVII Issue 4, July 2018).

Detention Officer Erby heard the broadcast of a Man Down in South Pod and responded to B-block. Upon arrival, Detention Officer Erby began to monitor and control the incident. Detention Officer Erby observed that MJS personnel were already performing CPR on Baca without the need for his direction, so he canvassed for witnesses and directed available staff to remove the inmates that could directly view the incident. Detention Officer Erby also recognized the need to preserve the crime scene so he directed personnel to tape off the area. Detention Officer Erby also continually utilized department resources to ensure that an RA was enroute.

The actions of Detention Officer Erby were consistent with Department training and my expectations of a senior officer during a critical incident.

Sergeant Barnes heard the broadcast of a Man Down and began to monitor the incident via his radio and the live-feed video cameras located within the module. Sergeant Barnes observed MJS personnel providing medical attention to Baca and also heard several requests for an RA to respond to the location. Sergeant Barnes initiated a chronological log to document the incident. Hearing that Baca was unresponsive, Sergeant Barnes made telephonic notifications. Sergeant Barnes also ensured both the MJS and medical staff that were involved in the incident were separated and monitored until the arrival of FID investigators.

The actions of Sergeant Barnes were consistent with Department supervisory training and my expectations of a Department supervisor during a critical incident.

General Training Update (GTU)

Sergeant Barnes and Officer Lee attended a GTU on July 25, 2019. All mandatory topics were covered, including In-Custody Deaths.

Additional/Equipment

Incomplete Arrestee Medical Screening Form – The investigation revealed that Officer Mann did not complete the Arrestee Medical Screening Form in its entirety. Officer Mann's actions resulted in unknown personnel completing the Arrestee Medical Screening Form inaccurately with a notation that Baca had an open wound on his leg. Officer Mann is reminded that the completion of the Arrestee Medical Screening Form in its entirety is essential in the processing of inmates. Captain Harrelson was advised of this issue. Captain Harrelson advised that this issue was addressed through informal training and the generation of a Supervisory Action Item (SAI). The Commanding Officer of Operations – Central Bureau (OCB) and the Director of the Office of Operations (OO) concurred with this action. As such, I deem no further action is necessary.

Administrative Segregation – The FID investigation revealed that on July 14, 2019, at approximately 0800 hours, Detention Officer Ramirez directed Officer Lee and Detention Officer Sanchez to place Baca into South-B-102, a single occupant segregation cell. Detention Officer Ramirez was assigned as a Lead Detention Officer (LDO) for the South housing modules. Lead Detention Officers are non-supervisory team leaders, who are tasked with

overseeing the completion of jail logs and delegating assignments to other staff members. Jail Operations Manual, section 2/204.06, states that "Administrative segregation is to be authorized upon approval of a jail supervisor." Detention Officer Ramirez' status as a LDO did not authorize him to place Baca in a segregation cell. Captain G. Newton, Serial No. 47010, Commanding Officer, CSD, was advised of this issue and addressed it through divisional training, the issuance of an Employee Comment Sheet, and the generation of a Supervisory Action Item (SAI). In addition to the corrective action for Detention Officer Ramirez, the subject of Administrative Segregation was briefed during all CSD roll calls for five consecutive days. The Commanding Officer of Administrative Services Bureau (ASB) and the Director of the Office of Support Services (OSS) concurred with these actions.[14] As such, I deem no further action is necessary.

Unescorted Medical Staff – The FID investigation identified that RN Gonzales was not escorted by jail staff for the July 14, 2019, 0900 hours, Q4 check. Jail Operations Manual section 2/214 requires that medial staff be escorted by jail personnel. Captain Newton was advised of this issue. Since medical staff personnel are not employees of the Police Department, but are instead managed by the Personnel Department, Captain Newton met with Doctor Manoukian, Managing Physician, Joanne O'Brien, Director, Medical Services Division, and Stephen Kalb, Nurse Manager, Personnel Department. Director O'Brien has reminded medical staff assigned to the jail of the requirement to have a jail staff escort, and the prohibition to conduct sick or pill call without such escort. Medical staff were reminded to request an escort when they conduct these services. In addition, all MJS jail staff have been reminded through roll call training that if a medical staff member is unaccompanied, to immediately notify a supervisor or LDO who will assign a jail staff member as an escort. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, I deem no further action is necessary.

CSD Observation Logs – Inmate Tracking – The FID investigation revealed that on July 14, 2019, at approximately 0800 hours, CSD staff did not properly document the relocation of Baca from the South-D housing module into the South-B-102 single occupant segregation module. CSD Observation Logs are used to document the inmate population in housing blocks to ensure inmate accountability and that overcrowding does not occur. Captain Newton was advised of this issue and addressed the deficiency through daily roll call training, focused on the importance of documenting all inmate movement, along with the proper procedure and sequence for documenting movement. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, I deem no further action is necessary.

Documentation of Title 15 Safety Check – Detention Officer Mason signed the CSD Observation Log on two occasions prior to completing the Title 15 safety checks. Detention Officers are directed to sign the CSD Observation Log upon completion of the Title 15 safety checks. Captain Newton was advised of this issue and addressed it through daily roll call training, focused on the importance of Title 15 safety checks, as well as the proper procedure and

[14] At the time of incident, Police Administrator G. Grube, Serial No. E8547, Commanding Officer, Administrative Services Bureau, retired, and Assistant Chief J. Peters, Serial No. 25750, Director OSS, retired, concurred with the corrective actions and discipline regarding involved personnel.

sequence for documentation of Title 15 safety checks. Additionally, Captain Newton directed all Title 15 checks to be reviewed daily by a CSD supervisor for accuracy. Further, CSD is in the process of replacing the written observation log with the Guardian Radio Frequency Identification (RFID) scanning system.[15] The Commanding Officer of ASB and the Director of OSS concurred with this action.[16] As such, I deem no further action is necessary.

Missed Title 15 Safety Checks – Detention Officer Mason missed a mandated Title 15 safety check for July 14, at 1632 hours, as a result of being re-directed to retrieve another inmate. Captain Newton was advised of this issue and addressed the failure through divisional training, the issuance of a Notice to Correct, and the generation of a SAI. Captain Newton also directed the creation of Divisional Order No. 5 titled, "Critical Importance of Title 15 safety checks and additional auditing responsibilities," to re-emphasize the importance of safety checks in order to verify the physical wellbeing of each inmate by observing signs of life and obvious signs of distress as required by State regulations. The order also established a procedure for in-person and video monitoring along with safety check auditing by a supervisor twice per watch where feedback is provided to the officer conducting the safety check. In addition, the disposition of these checks are included in the Watch Supervisor Daily Report. An audit was provided to the Commanding Officer, Support Services Group, for each Deployment Period identifying any abnormalities. The Commanding Officer of ASB and the Director of OSS concurred with this action.[17] As such, I deem no further action is necessary.

Improper Inmate Escort – When Detention Officer Mason was diverted from the July 14, 2016, 1632 hour, Title 15 safety check to escort another inmate for reasons unrelated to the ICD, Detention Officer Mason did not handcuff that felony suspect and conducted the escort alone. Detention Officer Mason's actions violated Jail Operations Manual section 2/100. Section 2/100 specifies that, "All felony inmates and any inmate, who is believed to pose a threat, should be handcuffed and escorted by two officers when being moved to or from a housing unit." Captain Newton was advised of this issue and addressed it through divisional training. In addition to training, Captain Newton directed the CSD handcuffing policy to be briefed for seven consecutive roll calls. The policy was vigorously discussed at the subsequent supervisor and OIC meetings. The Commanding Officer of ASB and the Director of OSS concurred with these actions.[18] As such, I deem no further action is necessary.

Improper Radio Broadcast – Officer Lee did not broadcast "Officer Needs Help" prior to entering Baca's cell alone and also broadcast the incorrect verbiage after entering Baca's cell. However, Jail Operations Manual section 1/260 provides an exemption to entering an occupied cell, "In an exigent, life threatening circumstance or the need to render medical aid to a lone

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[15] Guardian is a web based mobile inmate tracking system which includes an activity log, headcount, performs cell checks, tracks inmate movement, and provides compliance monitoring on demand by authorized CSD supervision.
[16] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.
[17] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.
[18] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.

occupant in a cell, a lone employee may enter the cell prior to the arrival of sufficient personnel." Officer Lee did broadcast "Man Down," but not until after he had already requested the opening of the cell door, entered the cell, and performed an initial assessment of Baca. Captain Newton was advised of this issue and addressed the issue through the revision of the Jail Operations Manual, section 1/260, to update the radio terminology to include the more accurate verbiage of "Man Down." A "Man Down" broadcast now not only initiates the emergency response of other jail personnel, but also summons the immediate response of Dispensary medical personnel. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, I deem no further action is necessary.

MJS Video Surveillance – The FID investigation revealed that both security video systems installed at MJS were determined to note the time of recording two minutes behind actual time. Captain Newton was advised of this issue and addressed the malfunction through the initiation of a work order with the City approved vendor, wherein, the time discrepancy was resolved. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, I deem no further action is necessary.

Cell Inspections – The FID investigation revealed that a cell intercom, not related to the ICD incident, was not functioning on the day of the incident. The FID investigators identified that intercom of the South-B-106 cell was not functioning on the day of the incident. Captain Newton was advised of this issue and addressed the malfunction through the initiation of a work order with the City approved vendor, wherein, the malfunction was resolved. Captain Newton also directed that Division Order No.7-2019 be reviewed for five consecutive roll calls.[19] The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, I deem no further action is necessary.

Body Worn Video (BWV) – Officer Heistermann had a late activation of his BWV device of approximately 29 seconds. An analysis by Central Area determined that Officer Heistermann had three prior BWV non-compliance incidents.

Officer Haskell had a late activation of his BWV device of approximately three minutes, 22 seconds. An analysis by Central Area determined that Officer Haskell had two prior BWV non-compliance incidents.

With regard to the issues related to BWV for both Officers Heistermann and Haskell, they were brought to the attention of Captain Harrelson who advised that these issues were addressed with the issuance of an Employee Comment Sheet, and the generation of a SAI for each officer. The Commanding Officer of OCB and the Director of OO concurred with this action. As such, I deem no further action is necessary.

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[19] Division Order No.7-2019 states, "Prior to placing an inmate into a segregation cell, the officers shall visually inspect the cell for any contraband, general damage, vent coverage, camera obstruction or damage. Jail facilities with inmate intercoms shall perform an intercom check with their respective housing unit, ensuring the intercom operates."

Audio/Video Recordings

Digital In-Car Video System (DICVS) – Central Patrol Division police vehicles were equipped with DICVS. Officers Haskell and Heistermann's police vehicle captured Baca being placed into the rear passenger compartment and his transport to Central CPS.

Body Worn Video – Central Patrol Division officers were equipped with BWV. Officers Haskell and Heistermann's BWVs captured the initial detention, arrest, and transport of Baca to Central CPS.

Other Video – Central CPS was equipped with a security video system that captured footage of Baca during his time at Central CPS.

The MJS is equipped with approximately 365 cameras that are connected to the Genetec and Verint closed circuit video systems. Each of these systems captured footage of Baca from the point Baca entered MJS until he was determined to be deceased by LAFD personnel.

Chief's Direction

While the UOFRB determined, and I concur, that the actions of Custody Service Division personnel did not contribute to Baca's death, the course and scope of this investigation identified the need for an adjudication system with regard to In Custody Deaths. As such, I am directing the Director of the OSS to finalize the Categorical Use of Force, In Custody Death Adjudication Process Order, currently being drafted by Critical Incident Review Division.

Respectfully,

MICHEL R. MOORE
Chief of Police

Date: 5-4-20